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PATIENT'S REQUEST FOR INFORMATION

From: Dentist Name & Address: _____

To: Name & Address: _____

Patient Name: _____ Date of Birth _____

I, _____, would like access to or a copy of my/my
child's protected health information. Please provide me with the following
information:

Records, x-rays, lab results, etc.

Patient's/Guardian's signature: _____ Date: _____